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TO: **Arkansas Medicaid Health Care Providers – Personal Care**

DATE: **March 1, 2005**

SUBJECT: **PROPOSED - Provider Manual Update Transmittal No. 58**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
200.110	8-1-04	200.110	3-1-05
200.140	8-1-04	200.140 – 200.143	3-1-05
201.000 – 203.000	Dates vary	201.000 – 204.000	3-1-05
213.500 – 213.510	10-13-03	213.500 – 213.510	3-1-05
215.360	10-13-03	215.360	3-1-05
217.110	7-1-04	217.110	3-1-05
219.000	10-13-03	219.000 – 219.200	3-1-05
		220.113	3-1-05
262.110	8-1-04	262.110	3-1-05

Explanation of Updates

Section 200.110: Part B has been deleted because Medicare does not cover personal care. The former part A now comprises section 200.110.

Sections 200.140 through 200.143: Effective for dates of service on and after March 1, 2005, Level I Assisted Living Facilities and Level II Assisted Living Facilities may enroll as Medicaid Personal Care providers. Former section 200.140 has been divided into 4 sections in order to implement this policy.

Section 201.000: The new section 201.000 explains that EDS has assumed provider enrollment responsibilities, effective January 1, 2005. It further explains that, EDS's new role notwithstanding, DMS and providers retain certain responsibilities.

Section 201.100: This section is former section 201.000. Revisions to it reflect 1) that EDS has responsibility for provider enrollment functions and 2) that certain persons and entities are not eligible to participate in the Medicaid Program.

Section 201.110: Former sections 201.010 and 201.020 have been combined and renumbered under a new heading, because Class A Home Health Agencies are no longer required to verify Medicare certification.

Section 201.120: This section has only been renumbered. Changes in its text merely reflect that the provider is responsible for ensuring that certain documents are on file with Provider Enrollment.

Sections 201.130 through 201.133: Former section 201.040 has been renamed, renumbered and subdivided.

Section 201.131: This section is the former section 201.040. The only other revisions to it are to reflect that EDS has assumed provider enrollment functions and that the provider is responsible for ensuring that certain documents are on file with Provider Enrollment.

Sections 201.132 and 201.133: These sections have been added to reflect that Level I Assisted Living Facilities and Level II Assisted Living Facilities are required to have copies of their licenses on file with the EDS Provider Enrollment Unit.

Section 201.140: This section is the former section 201.050. The only other revision is to reflect that EDS has assumed provider enrollment functions.

Section 202.000: This is a new section heading. The section contains no new policy. Its subsections, containing definitions and special participation requirements of routine services providers and limited services providers, previously had been numbered as if they were subsections of the provider enrollment procedures section.

Sections 202.100 through 202.210: These subsections were formerly sections 201.100 through 201.210. No other revisions have been made to them.

Section 203.000: This section was formerly numbered 202.000. The only other revisions are to reflect that EDS has assumed provider enrollment functions and that the providers must ensure that certain documents are on file with Provider Enrollment.

Section 204.000: This section was formerly numbered 203.000.

Section 213.500: Some text in the first sentence of part A has been revised to reflect the language in the Arkansas Title XIX (Medicaid) State Plan. Subparts 2 and 3 of part A have been changed for clarity only.

Section 213.510: This section has been revised to delete references to clients and individuals under the age of 21.

Section 215.360: This section has been revised to reflect that a secondary provider at a single service site may be any personal care provider that would be authorized to be a primary provider at the same site. Previous language in this section permitted only private care agencies to be secondary providers.

Section 217.110: This section has been revised to correct a formatting error.

Sections 219.000 through 219.200: These sections have been added to explain beneficiaries' rights in appealing adverse actions by DMS or its contracted designees.

Section 220.113: This section has been added to reflect that providers may use electronic media to the extent that such is permitted under Arkansas law.

Section 262.110: This section has been added to correct billing information distributed in earlier updates.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out of state at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

200.110 Class A Home Health Agencies 3-1-05

The Division of Health Facility Services, Arkansas Department of Health, must license a Class A Home Health agency before the agency may apply to enroll as a personal care provider.

200.140 Assisted Living Facilities 3-1-05

A. There are three types of assisted living facilities (ALFs). The three types are: Residential Care Facilities (RCFs), Level I Assisted Living Facilities (Level I ALFs) and Level II Assisted Living Facilities (Level II ALFs).

B. The Arkansas Office of Long Term Care (OLTC) certifies, licenses and regulates certain institutions, including ALFs.

C. Each ALF has a separate license, regardless of which type it is and regardless of its location or proprietorship.

D. Each ALF that provides personal care for Medicaid beneficiaries and that desires Medicaid reimbursement for those services must enroll separately in the Arkansas Medicaid Personal Care Program, effective for dates of service on and after March 1, 2005.

1. Some providers operate multiple ALF facilities, sometimes on the same property or in the same complex and sometimes in multiple locations.

a. Effective for dates of service before March 1, 2005, Medicaid covers personal care services provided by enrolled RCFs for residents of Level I ALFs and Level II ALFs under the same proprietorship as the enrolled RCF.

b. Level I and Level II ALFs that are not under the same proprietorship as a Medicaid-enrolled RCF may not contract for Medicaid-covered personal care with an enrolled RCF owned by another entity.

c. Except under the conditions described in part a above, personal care in any assisted living facility may be provided only by the facility itself, if it is enrolled in the Arkansas Medicaid Personal Care Program, or by

1) A private care agency that is enrolled as a Personal Care provider or

2) A Class A or Class B home health agency that is enrolled as a Personal Care provider.

2. Several provider files may share the same Federal Employer Identification Number (FEIN). For example: A corporate entity that has one FEIN owns an RCF and a Level I ALF and enrolls them as Personal Care Program providers.

a. Each facility is assigned a unique Arkansas Medicaid provider number.

b. Each facility's Arkansas Medicaid Personal Care provider number is linked to its unique license number.

c. Each facility's Arkansas Medicaid Personal Care provider number is linked to the corporate entity's single FEIN.

E. For dates of service before March 1, 2005, RCFs are the only assisted living facilities that may participate in the Personal Care Program.

F. Sections 200.141, 200.142 and 200.143 outline Arkansas Medicaid Personal Care Program participation requirements for RCFs, Level I ALFs and Level II ALFs.

G. In addition to the Personal Care Program, Level II ALFs may participate in the Living Choices Assisted Living Program.

1. Living Choices is a home- and community-based program established for certain nursing home-eligible individuals who, without a program like Living Choices, would not be able to live in a dwelling of their own or would be able to do so only with great difficulty and with significant risk to their health and safety.

2. Providers may obtain Living Choices Program participation requirements by downloading the Living Choices Assisted Living Provider Manual from the Arkansas Medicaid website, www.medicaid.state.ar.us.

200.141 Residential Care Facilities 3-1-05

A residential care facility applying for enrollment as a personal care provider must be licensed as a residential care facility by the OLTC.

200.142 Level I Assisted Living Facilities 3-1-05

A Level I ALF applying for enrollment as a personal care provider must be licensed as a Level I ALF by the OLTC.

200.143 Level II Assisted Living Facilities 3-1-05

A Level II ALF applying for enrollment as a personal care provider must be licensed as a Level II ALF by the OLTC.

201.000 Provider Enrollment 3-1-05

A. Effective January 1, 2005, EDS assumed provider enrollment functions for the Arkansas Medicaid Program.

1. The EDS Provider Enrollment Unit is automating, to the extent possible, provider enrollment tasks, including provider file maintenance.

2. The automated enrollment system includes provisions for obtaining and maintaining required enrollment materials and documentation by means of mail, personal contact and telephone contact.

3. The new enrollment system includes procedures by which enrolled providers and applicants for enrollment can easily query EDS regarding the status of their file.

B. The assumption of provider enrollment duties by EDS notwithstanding, the Arkansas Medicaid Program and Medicaid providers retain certain responsibilities.

1. The Division of Medical Services (DMS) retains ultimate authority to approve or disapprove provider applications and Medicaid contracts.

2. Applicants for Medicaid enrollment and enrolled Medicaid providers are ultimately responsible for ensuring that all required documentation is on file with the EDS Provider Enrollment Unit. Failure to provide required documentation on request and within specified timeframes will result in denial of a provider application or termination of a Medicaid contract.

   a. Whenever verification of a provider's licensure renewal is 30 days overdue, the Medicaid Management Information System (MMIS) generates a letter to the provider requesting that the provider forward a copy of the document within a specified timeframe.

   b. Providers may inquire at any time regarding the status of the documentation in their files by calling the EDS Provider Enrollment Unit. **View or print EDS Provider Enrollment Unit contact information.**

201.100 Provider Enrollment Procedures 3-1-05

A. All applicants for enrollment as personal care providers must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print form DMS-652, form DMS-653 and Form W-9. View or print EDS Provider Enrollment Unit contact information**.

B. The Arkansas Medicaid Program must approve all Medicaid provider applications and Medicaid contracts before enrolling providers. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

C. The Provider Enrollment Unit reviews, for accuracy and completeness, provider applications, Medicaid contracts and all other required documentation.

1. The Provider Enrollment Unit contacts applicants to correct errors or omissions in the enrollment documents. Some errors, such as failure to provide an original signature, necessitate returning the documents to the applicant for correction.

2. When the provider application materials are complete and correct and Arkansas Medicaid approves the application and contract, the Provider Enrollment Unit assigns a provider number, establishes a provider file and forwards to the provider written confirmation of the provider number and the effective date of the provider's enrollment.

D. Sections 201.110 through 201.140 list the documentation required of each type of applicant for enrollment as a provider in the Personal Care program.

201.110 Class A and Class B Home Health Agencies 3-1-05

Class A and Class B Home Health Agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current Class A or Class B license.

201.120 Private Care Agencies 3-1-05

A. Private care agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current license from the Arkansas Department of Health.

B. Private care agencies must ensure that there is on file with the Provider Enrollment Unit a copy of their current license from the Arkansas Department of Labor.

C. Private care agencies must ensure that there is on file with the Provider Enrollment Unit proof of liability insurance coverage of not less than one million dollars ($1,000,000.000), covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services.

D. Annually, private care agency providers must ensure that there is on file with the Provider Enrollment Unit proof that the agency's required liability insurance remains in force and has remained in force at a level of coverage no less than the required minimum since the provider's previous report.

201.130 Assisted Living Facilities 3-1-05

201.131 Residential Care Facilities 3-1-05

A residential care facility applying for enrollment as a personal care provider must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of its current license from the Office of Long Term Care (OLTC).

201.132 Level I Assisted Living Facilities 3-1-05

A Level I Assisted Living Facility (ALF) applying to enroll as a personal care provider must ensure that there is on file with the Provider Enrollment Unit a copy of its current license from the OLTC.

201.133 Level II Assisted Living Facilities 3-1-05

A Level II ALF applying to enroll as a personal care provider must ensure that there is on file with the Provider Enrollment Unit a copy of its current license from the OLTC.

201.140 Division of Developmental Disabilities Services Community Providers 3-1-05

A Developmental Disabilities Services Community Provider facility applying for enrollment as a personal care provider must ensure that there is on file with the Provider Enrollment Unit a copy of its current license from the Arkansas Division of Developmental Disabilities Services.

202.000 Routine Services Providers and Limited Services Providers 3-1-05

202.100 Routine Services Providers 3-1-05

Routine services providers in the Arkansas Medicaid Personal Care Program are enrolled Medicaid providers who, in accordance with the regulations of the Arkansas Medicaid Program,

may provide medically necessary services to eligible and qualified individuals who choose to receive their services.

202.110 Personal Care Providers in Arkansas 3-1-05

Enrolled Personal Care providers in Arkansas qualify as routine services providers. However, some personal care providers are limited to providing services only in certain places of service. See section 213.000, part F.

202.200 Limited Services Providers 3-1-05

Generally, limited services providers are providers in states not bordering Arkansas that are allowed to participate in Arkansas Medicaid only in order to provide emergency or prior authorized services.

202.201 Limited Services Providers and Emergency Services 3-1-05

Personal care is not an emergency service, as emergency services are defined in title 42, Code of Federal Regulations (42 CFR). Therefore, personal care providers in states not bordering Arkansas do not qualify as limited services providers of emergency services.

202.202 Limited Services Providers and Prior Authorized Services 3-1-05

A. Services that are prior authorized to be furnished by a limited services provider must always be medically necessary and, in most cases, not available in Arkansas.

1. In the Personal Care Program, the requirement that the service not be available in Arkansas may be waived when a personal care client is temporarily out of the state.
    a. See section 213.600 for policy guidelines regarding personal care clients who temporarily change location and must transfer their care to a local provider.
    b. When the temporary location is in another state, the Arkansas Medicaid Program may allow a personal care provider in that state to enroll as a limited services provider to furnish the client's services during the stay.
2. Personal care for clients temporarily in another state requires prior authorization.
3. Personal care for clients temporarily in another state is subject to the additional regulations in sections 213.600 and 213.610.

B. Send written requests for prior authorization to the Division of Medical Services, Utilization Review Section. **View or print Division of Medical Services, Utilization Review Section contact information**.

1. Upon notification of the prior authorization, the provider may submit to the EDS Provider Enrollment Unit the provider application (form DMS-652), Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print form DMS-652, form DMS-653 and Form W-9**. **View or print EDS Provider Enrollment Unit contact information**.
2. Additionally, the provider must submit appropriate licensure, certification or other documentation required by Arkansas Medicaid to establish that the applicant is a qualified personal care provider.

C. Prior authorization does not guarantee payment for the service.

The beneficiary must be Medicaid eligible on the dates of service and must have available benefits.

The provider must follow the enrollment procedures in Sections I and II and the billing procedures in Sections II and III of this manual.

D. Limited services providers must submit paper claims directly to the Division of Medical Services, Utilization Review Section. **View or print Division of Medical Services, Utilization Review Section contact information**.

202.210 Personal Care Providers Not Licensed in Arkansas 3-1-05

A. Personal care providers licensed only in other states may not provide services in Arkansas.

B. Providers that are licensed in other states and that are not licensed in Arkansas may enroll in Arkansas Medicaid as limited services providers only.

203.000 IndependentChoices Waiver; Counseling and Fiscal Agent Enrollment 3-1-05

IndependentChoices is a Cash and Counseling Demonstration and Evaluation Project. IndependentChoices seeks to increase the opportunity for consumer direction and control for Medicaid recipients receiving or needing personal care by offering a cash allowance and counseling services in place of traditionally provided personal care.

A. The goal of the IndependentChoices Program is to evaluate the efficiency and feasibility of a Medicaid personal care program that offers consumer direction and control with a monthly cash allowance.

B. As the single State agency authorized to contract for Medicaid services, the Department of Human Services (DHS) developed and received approval of a Section 1115 research and demonstration waiver to provide IndependentChoices to adults (aged 18 and older) with disabilities and the elderly (aged 65 and older). IndependentChoices is administered by the Division of Aging and Adult Services (DAAS).

C. The Division of Medical Services contracts with counseling agencies to provide counseling and fiscal services. The counseling and fiscal agent services agencies have been selected through a Request for Proposal (RFP) process. One Counseling and Fiscal Agent (CFA) has been selected for each of four regions.

1. Each CFA selected must submit a provider application (form DMS-652) and Medicaid contract (form DMS-653) to the Medicaid Provider Enrollment Unit for enrollment as a Medicaid provider. **View or print form DMS-652. View or print form DMS-653. View or print EDS Provider Enrollment Unit contact information.**

2. Each CFA must ensure that the Provider Enrollment Unit has on file a letter from DAAS verifying that the CFA has DAAS approval to enroll as a Medicaid provider.

204.000 Record Requirements 3-1-05

A. Providers are required to keep the records described in section 221.000 and, upon request, to furnish the records to authorized representatives of the Arkansas Division of Medical Services, the state's Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services.

B. All required records must be kept for a period of five years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.

C. Furnishing records on request to authorized individuals and agencies listed above in part A is a contractual obligation of providers enrolled in the Medicaid Program. Sanctions will be imposed for failure to furnish medical records upon request.

D. When the Medicaid Field Audit Unit of the Division of Medical Services (DMS) conducts an audit of a provider's records, all documentation must be made available to authorized DMS

personnel at the provider's place of business during normal business hours. When requested records are stored off-site, the provider will be allowed up to three business days to make them available to Field Audit staff.

E. If an audit determines that recoupment of Medicaid payments is necessary, DMS will accept additional documentation for only thirty days after the date of the notification of recoupment. Additional documentation will not be accepted later.

213.500 Personal Care Service Locations 3-1-05

A. Arkansas Medicaid covers personal care in a client's home and, at the state's option, in another location, for clients of all ages.

1. A client's home is the client's residence, subject to the exclusions in part B, below.
2. Service locations outside the client's home must be included in the service plan. (If shopping or assistance with shopping is included in the service plan, it is understood that the actual activity occurs at a store. The place of service—for billing purposes—remains the client's home.)
3. The client's assessment and service plan must justify the medical necessity for personal care in a location other than the client's residence. For example: A client's service plan includes assistance with dressing. This particular client regularly (by PCP referral or a physician's order) goes to a clinic or other site for a therapy, such as aqua therapy, that involves changing clothes. If, at the therapy site, assistance with dressing and/or changing is not included with the therapy service, the personal care service plan may include an aide's assistance. However, in such a situation, only the time the aide spends performing the service is covered.

B. Medicaid does not cover personal care services in the following locations:

1. A hospital,
2. A nursing facility,
3. An intermediate care facility for the mentally retarded (ICF/MR) or
4. An institution for mental diseases (IMD).

C. All individuals residing in locations listed above in part B are ineligible for Medicaid-covered personal care.

D. Individuals who are inpatients or residents of the facilities and institutions listed in part B are not eligible for Medicaid-covered personal care services in any location.

213.510 Personal Care in Division of Developmental Disabilities Services (DDS) Community Provider Facilities 3-1-05

A. Medically necessary personal care is covered in a DDS community provider facility.

B. Medicaid Program requirements are the same as for personal care services delivered in a client's home.

C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid programs, through which the client receives services.

D. Individuals enrolled in DDS community provider facilities may receive a number of services in accordance with an Individualized Plan (IP), an Individualized Family Services Plan (IFSP) or an Individualized Habilitation Plan (IHP).

1. None of these plans may supersede or substitute for the personal care service plan.
2. The Personal Care Program requires a distinct and separate assessment and service plan.

215.360 Service Plan Requirements for Multiple Providers 3-1-05

A. A client may have two personal care providers at a single location if the secondary provider furnishes services during hours in which the primary provider does not operate or does not have an available personal care aide, such as on weekends or at night.

B. Each provider must develop an individualized service plan.

1. The providers should cooperate in the development of the service plans.

2. Authorization of both service plans must be by the same physician.

217.110 Provider Notification of Benefit Extension Determinations 3-1-05

A. DMS will approve or deny a benefit extension request—or ask for additional information—within two weeks.

1. DMS reviewers will advise the provider of their decision by means of the Provider Notification page of form DMS-618. **View or print form DMS-618**.

2. Notification of benefit extension approval includes:

   a. The procedure code approved,

   b. The total number of units approved for the procedure code,

   c. The benefit extension control number and

   d. The approved beginning and ending dates of service.

B. The DMS reviewers who approved or denied the request sign and date the notification.

219.000 Beneficiary Due Process 3-1-05

219.100 Appealing an Adverse Decision 3-1-05

A. When DMS denies coverage of personal care services or denies a benefit extension request for personal care, the client may appeal the denial and request a fair hearing.

B. An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the letter from DMS explaining the denial. **View or print the Department of Human Services, Appeals and Hearings Section contact information**.

219.200 Requesting Initiation or Continuation of Services Pending the Outcome of an Appeal 3-1-05

A. A client may request that services be continued (or that services begin, in cases where coverage has been denied), pending the outcome of an appeal.

1. Appeals that include a request to begin or continue services must be received by the DHS Appeals and Hearing Section within 10 days of the date on the DMS denial letter.
2. When such requests are made and timely received by the Appeals and Hearings Section, DMS will authorize the services and notify the provider and beneficiary.
3. The provider will be reimbursed for services furnished under these circumstances and for which the provider correctly bills Medicaid.

B. If the beneficiary loses the appeal, DMS will take action to recover from the beneficiary Medicaid's payments for the services that were provided pending the outcome of the appeal.

220.113 Service Logging by Electronic Media 3-1-05

A. Personal care aides may log the times that they begin and end services, as well as the services themselves, by electronic media, such as telephony.

B. Electronic signatures, as permitted under Arkansas law and as defined in Section IV of this manual, are allowed in the Personal Care Program.

C. All Arkansas Medicaid documentation requirements must be met, regardless of documentation media.

262.110 Place of Service Codes for Paper and Electronic Claims 3-1-05

Place of Service	Paper Claims	Electronic Claims
Client's Home*	4	12
DDS Community Provider Facility**	5	99
Public School***	S	03
Other Locations****	0 (zero)	99

* The client's home is the client's residence, subject to the exclusions in section 213.500, part B. For example, if a client lives in a residential care facility (RCF) or an assisted living facility (ALF), then the RCF or ALF is the client's home and is so indicated on an electronic claim by place of service code 12.

** A Division of Developmental Disabilities Services Community Provider Facility, for clients under age 21 whose instruction is not the responsibility of the client's school district or for clients aged 21 and older. **NOTE: There is no HIPAA-approved place of service code for a developmental disabilities clinic or habilitation facility. Providers must use place of service code 99—"Other Place of Service" for this designation.**

*** Personal Care services provided by a school district or education service cooperative require place of service code S and type of service code S on paper claims. See section 213.520 for a full explanation of the "public school" place of service.

**** *Not* a public school.